MEDICATION ADMINISTRATION POLICY AND PROCEDURE

POLICY TITLE and number	**# 800 Medication Administration**
HEADER INFO - Adopted - Revised	**Adopted 12/89** **Revised 11/92, 10/94, 08/02, 08/06, 9/06, 08/14, 6/21**
RULE REFERENCE	**5123:2-6; 5123:2-6-07**
GLOBAL POLICY STATEMENT (what and why)	MEDICATION ADMINISTRATION CICL shall develop written procedures for giving or applying prescribed medication and OTC medication to individuals which includes, but is not limited to, the dose, time, frequency, and route of the medication taken, as well as documenting any significant responses to the medication, occurrences of undesirable side effects of the medication, and errors in medication administration. Policies and procedures will also be developed for any health-related activities. CICL staff that administer medications must have the appropriate Medication Administration Certification. The CICL administrative team will ensure that all direct support staff have Medication Certification 1 to pass oral and topical medications. Each staff member that administers Oral and Topical medication will be required to attend and pass the 14 – Hour Medication Administration training. If an individual selected requires medications to be administered by a G-tube/J-tube, the CICL administrative staff will ensure staff administering the medications have current certification for the Medication Certification 2 category. Additionally, if individual selected requires Insulin injections, the CICL administrative staff will ensure the staff have Medication Certification 3. All staff administering Insulin injections must be supervised by an agency Registered Nurse (RN). CICL staff members will be required to renew their certification on an annual basis. To ensure the agency remains compliant in this area, a tracking mechanism has been developed to track the period of time when the certifications are valid. The agency shall comply with the requirements for reporting errors established under paragraph (D) of Rule 5123:2-6-07 of the Administrative Code. These records shall be retained as part of the individual's record.
GUIDELINES/PROCESS STATEMENTS (how)	**Physician's Orders** Maintain the written medication order in the client's QUICKMAR file. The written order includes: • Name of the medication • Amount of medication to be given (dosage) • How it is given (i.e. apply to rash and rub in) • Where on body to apply, if topical • Date to start medication (if other than date ordered) • Date to stop medication (if applicable) • How often it is taken (frequency) and the specific times it is taken

- Symptoms requiring a PRN (as needed if necessary) medication

Do not carry out any prescription or over-the-counter medication changes, substitutions, or omissions without the order of the physician. Do not administer any medications for reasons other than that as prescribed by the physician.

Medication Changes

Program Manager and/or the Pharmacy document medication changes (i.e. changes in frequency, dosage, times), deletions and new orders immediately in the QUICKMAR medication record and in the program record following a physician's order.

Program Manager or direct care staff complete the following to notify vocational programs:

Montgomery County:

- Deliver a copy of the County Form signed by the physician. See the client's file for the vocational program location address. If the form is not delivered prior to the medication change, Choices In Community Living, Inc. staff travel to the vocational site and administer the medication until form is delivered.

Clark, Warren, Greene and Butler County:

- Fax a copy of the medication administration form. See the client's file for the vocational program fax number. If the form is not faxed prior to the medication change, Choices In Community Living, Inc. staff travel to the vocational site and administer the medication until form is faxed.

Madison and Preble County:

- Fax a copy of the doctor's order to the delegating nurse employed by the county. See the client's file for the delegating nurse's fax number.

Program Administrator or direct care staff document the physician's order for a medication or medication change immediately in the client's record if the order is given verbally by telephone. Written and signed verification of the order by the prescribing physician is received within seven days.

When the physician's order is given to the Pharmacy, the exact times the medication is to be administered will be identified. If the prescription does not specify times but states only the frequency, divide the client's waking hours by the frequency to determine the length of time between medication dosages so the client receives the medication at equal intervals.

Federal law prohibits the transfer of prescription medication to any other person than to whom it was prescribed.

Prescription Terminology

Program Administrator or direct care staff maintain a copy of the Prescription Terminology with the medication administration records. Should an abbreviation be used that is not on the list, consult with the agency nurse, doctor or pharmacist regarding the abbreviation. Add the terminology explanation to the list.

Supply

The Program Administrator or designee maintains an adequate supply of medications at all times and ensure monthly re-ordering of medications are completed. Direct care staff will notify their supervisor when medication supplies are running low to ensure refills have been ordered and to prevent a lapse in medications being dispensed.

Clients who self-administer medications maintain the amount of medication indicated in their Individual Service Plans.

Storage

Store all prescription and non-prescription medications in a locked area. Lock medications that require refrigeration in a separate locked container in the refrigerator or lock the refrigerator, provided another unlocked refrigerator is available for the clients living in the home. The Program Administrator and direct care staff are responsible for the keys. Maintain the keys in a location which ensures they are not misplaced or found and used by non-staff individuals.

Clients who self-administer their medications maintain the medications in a secure area. The area is locked if the client has a roommate unless the client's and roommate's Interdisciplinary Teams determine that storing the medication in a locked area is not necessary.

Store all medications in pharmacy labeled containers. Store oral medications separate from topical medications.

Clients who self-administer medication may store their medication in pillboxes designed to assist with recognition of times, days, etc.

Managing Controlled Medication:

Special care is required in the management and administration of controlled medications. This care is important so that an individual receives the prescribed amount of the controlled medication (not too much because they can be addicting, not too little so as to not treat the symptoms prescribed for) as well as ensuring the security of the controlled medication. If there is some question about if a medication is a controlled substance, you should consult with the Delegating Nurse or visit the web site www.usdoj.gov/dea/puls/scheduling.htmit

The Following procedures are required for all controlled substances:

1. Storage- All controlled medications must be kept in a locked container or cabinet. The key to the container/cabinet shall be forwarded to the next staff coming on duty during the pill count.
2. Counting- If the Controlled medication is a PRN it must be counted by staff during the beginning and at the end of their shift. (Count kept on QuickMar or see attached form) The program supervisor is expected to monitor this process closely. If the controlled med is prescribed on a daily basis, the medication must be counted each time the medication is given. The count is kept on Quickmar or a sheet is provided by the Pharmacy.
3. Destruction of Controlled Medications- If a controlled medication is discontinued or no longer required by the individual a final count must be made by two CICL personnel and a disposal log completed. The medications and the log are brought to the CICL front desk who will immediately forward the medications to the Delegating Nurse.

Administration with Assistance

Administer prescription medications only by the written order of the prescribing physician and according to the instructions.

Document the administration instructions for prescription medication on the medication administration record. Document symptoms requiring the client to take PRN medications on the medication administration record. Administer PRN medications per doctor recommendations listed in the Annual Physical Examination, 90 Day Medication Review or medication administration record.

Medications and health related tasks are administered and performed only by trained and designated staff per medication procedures, Ohio Adm. Rule, 5123:2-6-06 and the Individual Service Plan, or by the client as noted in the client's Individual Service Plan. All new staff must complete medication administration and health related tasks training. New staff must administer medications and perform health related tasks under the observation of a trained staff prior to performing health tasks or administering medications without supervision.

Administer non-prescription medications only as documented by the client's physician in the Annual Physical Examination or 90 Day Medication Review or by specific written order. The physician updates the allowed over-the-counter medications every 90 days. Whenever an over-the-counter medication is given, document the administration instructions, date(s), time(s), dosage(s) and name of staff administering medications on the medication administration record.

Always give medications within 60 minutes before or 60 minutes after the time for which they are prescribed. If medication is not given within this time, do the following:

- For all prescription medications and oral over-the-counter medications:
    - Do not give the medication.
    - Contact the Program Administrator.
    - The Program Administrator or Program Director determine if it is necessary to contact the physician or pharmacist or refer to the medication information sheets based on the type of medication, frequency given, etc. for instructions.
    - Document the time error, contacts made and information received on the medication administration record, program record, and unusual incident report.
    - Follow the procedure for reporting an unusual incident.

- For topical over-the-counter medications:
    - Administer the medication.
    - Document the time error on the medication administration record.
    - Follow the procedure for reporting an unusual incident.

All medication errors must be reported to the supervisor as soon as possible. Supervisor will contact medical professionals to determine if the medication error will adversely affect the individual's health and welfare. Document all medication errors on the medication administration record, program record, client's record and an Unusual Incident Report form. State on the Unusual Incident Report form how the client responded to the medication

	error, what steps were taken to ensure their health and safety as a response to the medication error. Supervisors will include on the unusual incident report what steps are taken to prevent future errors.
	
	Self-Administration
	• Clients may self-administer their medications according to their Individual Service Plans. The Individual Service Plan documents:
	  o The medications to be self-administered
	  o The amount, type, and frequency of staff monitoring
	  o The amount of medication to be kept by the client at one time
	  o Recording procedures
	  o Storage of medications
	
	Maintain medication administration records for clients who self-administer their medications as per their Individual Service Plans. Clients' ability to self-administer medication is assessed annually and their Individual Service Plans reviewed quarterly. For those clients who have demonstrated the skill to self-administer medications accurately, their Interdisciplinary Teams may determine that medication administration records are not necessary.
	
	Monitoring
	Medication side effects are always a concern. Refer to the Physician's Desk Reference and medication information sheets to obtain information about medication side effects.
	
	If undesirable side effects appear as the result of a medication, notify the physician and document the observed side effects in the client daily progress notes and administrative notes.
	
	Observe clients closely for allergic reactions or side effects when administering newly prescribed medications.
	
	Address questions regarding medications, side effects, or allergic reactions immediately. Never hesitate to call the physician, pharmacist or Poison Control when concerned about possible adverse reactions to medications. Document all reactions to medications and all information received through these contacts in the client record and program record.
	
	Administration of Medications when Clients are away from home
	Choices In Community Living, Inc. provides medications for administration any time the client is away at the time the medication is normally received (i.e. work, school, family visits, activities, appointments, etc.).
	
	Store the medications prescribed to be taken while the client is away in original containers from the pharmacist, if possible. The medication container label contains the client's name, the name of the medication, the dosage, times to be given and any special instructions.
	
	Provide complete written instructions on the Non-Staff Medication Administration Record for the responsible person who will administer medication or monitor self-administration of medication. Note the pill count on the Non-Staff Medication Administration Record and

	direct the person accepting the medication to sign the form. The responsible person maintains the Non-Staff Medication Administration Record and turns in the form upon return. Maintain the form in the client's file. **Destruction of Medication (non-controlled medications)** It is the policy of CICL to dispose of prescription drugs in a manner following Federal Guidelines and other processes established by state regulations to ensure the safe keeping and proper disposal process. Federal Guidelines: Do not flush drugs down the toilet or drain unless the label or accompanying patient information specifically instructs you to-do so. To dispose of prescription drugs not labeled to be flushed, you may be able to take advantage of pharmacy and community drug take back programs or other programs, such as household hazardous waste collection events, that collect drugs at a central location for proper disposal. When a client's prescribed medication is discontinued, or the expiration date of the medication is reached the preferred method of CICL for the disposal of drugs is to return them to the pharmacy. 1. Place the individually packaged medications in a separate container. Document the medications, prescription numbers, amount of medication being returned and the client to whom the medication was prescribed on the medication discard form or a form provided by the pharmacy. Place a copy of the form in the client's record. 2. Give the container to the pharmacy delivery person at the next delivery. 3. Have the delivery person sign a form indicating they have received the specific medication to be returned. 4. IF the pharmacy is not able to accept returned medications to be destroyed, place the medications in a safe container such as a baggie and transport them to the CICL central office to be placed in the hazardous waste container. Complete the form indicating the drugs were destroyed. 5. Document the destruction of shared medications or medications for an individual client in that month's program record under comments and in that day's program record. Include the date, name of the medications and signatures of both staff members in the record and the log. Also document the destruction on the medication discard form. Place it in the client file. **Physician Medication Reviews** Choices in Community Living, Inc. takes reasonable measures to ensure that the medications taken by clients are necessary. Clients taking medications that can only be purchased by prescription and/or medications that can be purchased over-the-counter that are taken regularly are required to visit their physician every 90 days for a review of the continued appropriateness of the medication. If the physician feels a review of a medication is not necessary every 90 days, the physician documents that fact and when the client should return for medication review on the appointment form. Choices In Community Living, Inc. is then not required to have those medications reviewed until the time the physician recommended unless there are problems.

	An example of a possible exception to the 90-day medication review rule may be birth control pills. An example of medications that should be reviewed are anticonvulsants and psychotropics. Clients taking medications that can be purchased over the counter are required to visit their physician annually for a review of the continued appropriateness of the medication if it is ordered PRN. Clear parameters for administering over the counter medications and PRN meds should be noted on the annual review by the physician. **Medication Error Disciplinary Process & Certification** CICL provides training to employees to ensure proper medication administration for the individuals we assist. Whenever there is any uncertainty in how medications should be administered, it is EXPECTED for phone calls to be made to the supervisor and OnCall Nurse for clarification. Medication errors can result in serious consequences for these individuals. The most common types of medication errors include, but are not limited to: • Wrong medication • Wrong dosage • Wrong route • Wrong date/time • Wrong consumer • Giving Expired Medications • Giving discontinued Medications Every time a medication error occurs, an Unusual Incident Report mush be completed. The Agency Nurse reviews all UT/MUI and determines which are medication errors for an employee. Together, the Program Administrators, Program Directors and Agency Nurse will follow up with an appropriate response, up to and including, Following the policy guidelines below. All follow up is required to be documented with copies provided to the HR department. FIRST MEDICATION ERROR (in a 12-month period beginning with first error) • PA will review the error with employee, and document on an Inservice Form, giving a copy to the Director, Director of Nursing and HR for employee file. SECOND MEDICATION ERROR (in a 12-month period beginning with first error) • PA will review the error with employee and document a verbal warning on Inservice Form, giving a copy to the Director, Director of Nursing and HR for employee file. • Verbal warning will include a Performance improvement plan. THIRD MEDICATION ERROR (in a 12-month period beginning with first error) • PA will review the errors with the employee and document a written warning on Inservice Form, giving a copy to Director and HR for the employee file. • The employee is suspended Supervisor review with employee, counseling, performance enhancement training. • Employee is suspended from passing medications until they have one-on-one training with Agency Nurse --which may include observation of a med pass.

FOURTH MEDICATION ERROR (in a 12-month period beginning with first error)

- PA will review the errors with the employee and document a final warning on Inservice Form — giving a copy to Director and HR for employee file.
- The final warning will include a performance improvement plan.
- Employee is suspended from passing medications until they successfully complete the Initial Medication Administration Class.
- Documentation of successful completion of class given to Director and HR for employee file.
- Documentation of successful medication pass observed by Agency Nurse will be given to Director and HR for employee file.

FIFTH MEDICATION ERROR (in a 12-month period beginning with first error)

- Suspended from passing medications for CICL
- Likely removal from current job role, including reduction in pay status

If Staff get their Medication Administration Certificate #1, or Certification #2 or Certification #3, revoked, and/or suspended, by some other Agency, the Staff member is responsible to let our Agency know about these actions.
Failure to provide the information can lead to further disciplinary action by the Agency

Identifying Sickness/Illness

Choices In Community Living, Inc. is committed to maintaining the safety and good health of its clients.

If a client becomes ill (i.e. complains of or indicates headache, stomach ache, etc.):

1. Take the client's temperature, if applicable.
2. Administer the over-the-counter medication that is recommended by the client's doctor.

If the illness persists:

3. If the illness persists for several hours, notify the client's doctor and/or take the client to the emergency room.
4. Follow the procedure for defining and reporting Major Unusual Incidents and Unusual Incidents.

If a client is injured:

1. Immediately determine whether first aid or emergency medical service is necessary.
2. Administer first aid or call 911, as applicable.
3. Follow the procedure for defining and reporting Major Unusual Incidents and Unusual Incidents.

The overnight or early morning staff assesses the client's condition and assists in determining if the client will attend day programming. The overnight or early morning staff notifies the Program Administrator of the decision and notifies the day program provider if the client will not attend.

Urgent Situations
There are several levels of urgent situations which require speed of action and medical care appropriate to the situation. Stabilize and evaluate minor injuries on the site and later transport either to the hospital or home, as applicable. Major illnesses and injuries require hospital care within the hour. Emergencies require action within minutes. When an individual appears to have a medical emergency, staff are expected to immediately contact 911 and provide emergency care as trained in Red Cross guidelines of CPR and First Aid treatments.

An emergency is a life-threatening condition in which death or permanent disability may result within the hour. Examples of these conditions are:

- Lack of heartbeat
- Lack of breathing
- Impairment of breathing
- Blow to head comparable to that of a strongly swung baseball bat
- Uncontrolled bleeding
- Coma
- Unconsciousness
- Poisoning
- Status epilepticus (long seizures)
- Crushing injury of head, chest, or abdomen
- Fractures of the long bones of the extremities
- Severe bee sting (allergy), massive hives, difficulty breathing secondary to throat swelling

Signs and symptoms to observe and report
Some situations may not be urgent, but it is important to recognize signs and symptoms of disease and/or side effects of medication so that proper treatment may be carried out. Choices In Community Living, Inc. expects all persons in contact with the clients to call attention to the first signs of problems noted through observations of baths, meal times and recreation periods. Some of the common symptoms to report to the Program Administrator and possible referral to the physician are listed below:

General Body Symptoms	**Vital Signs**
Weight loss without dieting (5 lbs)	Temperature elevation
Rapid weight gain (5lbs)	Low temperature
Loss of appetite	Weak, thready pulse
Increase in thirst	Irregular pulse
Dehydration	Fast or slow pulse
Dizziness, weakness	Shallow or deep respiration
Shaking, chills	Noisy respiration
Frequent or severe headache	Difficulty in breathing
Swelling in any part of the body	Pain or Injury

Ears	**Nose**
Discharge or bleeding	Chronic discharge

Pain in ear or back of ear
Foreign body in ear
Profuse hardened ear wax
Signs of deafness

Runny nose (not chronic)
Sneezing
Repeated nosebleeds
Foreign object in the nose
Breathing difficulties

Eyes
Redness of eyes or eyelids
Change in color, bluish or yellowish swelling
Discharge or bleeding
Profuse tearing
Dullness, brightness, dark circles
Twitching, sensitivity to light
Dilated or contracted pupils
Foreign body in the eye
Signs of blindness

Mouth
Tongue - coated, red, pale
Teeth - sharp, broken, loose, toothache
Gums - swelling, bleeding, ulcer sores that do not heal
Difficulty in swallowing or talking
Hoarseness
Swollen, discolored lips
Rash or red mouth
Sore throat

Abdomen
Any swelling or lump in the abdomen or groin
Nausea or vomiting
Pain in the abdomen
Rigid abdomen

Neck
Swelling or lumps in neck
Swelling, ulcer
Stiffness or pain in neck

Chest
Chronic cough
Coughing up blood or pus
Shortness of breath or difficulty breathing
Pain in chest
Lump in breast or under the arm

Skin
Rash, moles, open sores
Dryness, dampness
Pale or reddened bruises
Burns
Unusual bites

Rectum
Hemorrhoids
Bleeding or drainage from rectum
Abnormal bowel movements (blood, mucous, worms, diarrhea, fluid)
Chronic constipation

Feet
Swelling or pain
Corns or bunions
Ingrown toenails
Deformities
Blisters

Genitals and Urine
Swelling
Redness
Discharge
Itching
Abnormal color or odor of urine
Pain or difficulty in urination
Unable to void; voids frequently
Incontinence
Abrasions
Odor

Arms and Legs
Swelling or pain
Deformities
Lumps, bruises
Paralysis or weakness

Mental State
Coma or semi-comatose
Confusion or disorientation (unusual for client)
Drowsiness or stupor

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<tr><td></td><td>Varicose veins
Fatigue
Agitated
Sudden change in behavior

Do Not Resuscitate Orders
<u>Emergency Medical Response IF Client Is Not Under the Care of End-of-Life Services (such as Hospice)</u>
When an individual appears to be having an Urgent Emergency medical situation as described on pages 8 and 9 of this policy, staff will immediately take all reasonable steps to obtain emergency medical assistance and to preserve the individual’s life until the individual is under the direction or care of proper medical authorities.

<u>Staff Response IF Client IS under the care of End-of-Life Services (such as Hospice) but still living at home</u>
It is the policy of Choices In Community Living to take all reasonable steps needed to preserve the life and safety of individuals receiving services. If CICL is provided a written, current and legal DNR Comfort Care directive or a DNR Comfort Care-Arrest directive, this information will be maintained by CICL in permanent record and at the place of residence.
All DNR orders will include the protocol for DNR Comfort Care or DNR Comfort CareArrest per Ohio Administrative Code/Ohio Department of Health Rule 3701-62-04 and3705-62-05. (see attached).
The DNR directive and CICL’s policy regarding DNR orders will be reviewed and documented with the individual, the individual’s family and guardian, CICL’s Delegating Nurse, the county board Service and Support Administrator, and CICL staff.
The individual’s ISP should be revised to reflect the DNR order
CICL staff will be given written, simplified, and clear protocol to follow regarding the DNR order by the qualified End of Life Service provider (such as Hospice). These protocols will identify the actions CICL staff should implement. The protocol should instruct staff to contact the End of Life provider immediately when the individual begins to experience urgent medical issues, cardiac, or respiratory arrest to obtain their assistance.
Sharps Container Procedure
Needles and anything with blood on it must be disposed of in the home's Sharps Container.
No paper or gloves go into the Sharps Container.
Once the Sharps Container is 75% full, the PA must close the top. Then, tape the top down so that no one can open the container and get to the used hazard contents.
Per new regulations, the Sharps container can be thrown into the regular trash.</td></tr>
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Titles of forms</td><td>Appendix I -Prescription Terminology
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	Appendix V – Administering Medication Through Inhalers Appendix VI – Administering Nasal Sprays and Atomizers Appendix VII – Administering Nose Drops Appendix VIII – Administering Oral Medications Appendix IX – Administering Rectal Medications Appendix X – Administering Topical Medications Appendix XI – Individual Specific Training
TRAINING Titles of training	Individual Specific Training